DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services – Region IV

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June 20, 2001

Dear Medicaid Program Integrity Director for:
Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia, & Wyoming

As you may be aware, the Health Care Financing Administration (HCFA) has been recently re-named to the Centers for Medicare and Medicaid Services (CMS).

Regulations at 42 CFR 455.12-23 require States to have a process in place that meets certain requirements for investigating, pursuing, and referring suspected cases of fraud and abuse to law enforcement officials. When the Southern Consortium assumed the leadership role for the National Medicaid Fraud and Abuse Initiative in June 1997, we queried States about how we could assist them in their Medicaid program integrity efforts. One area of interest mentioned by the States was the operation of a more effective Surveillance and Utilization Review Subsystem (SURS). Coupling this idea with the responsibility of CMS to provide program integrity oversight, we conducted reviews in eight States in FY 2000.

Enclosed is the *Reviews of State Medicaid Program Integrity Procedures National Report* for Fiscal Year 2000. This report summarizes observations gathered during the reviews conducted in Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia, and Wyoming. Comments from your staff played a significant role in the preparation of your State's report. We hope this summary report will benefit Medicaid fraud and abuse efforts in all States.

The potentially beneficial practices and proposed enhancements mentioned in this report summarize the findings of the reviewers. We hope this report will assist you in assessing where your State fits along the fraud and abuse prevention continuum, and in selecting appropriate enhancements that fit your needs.

We have also attached for your information a transmittal issued by the DHHS Office of the Inspector General clarifying its policy with respect to investigation, prosecution, and referral of civil cases, as well as criminal cases, by the Medicaid Fraud Control Units (MFCUs). The MFCUs have been actively pursuing criminal cases that have been referred to them by State Medicaid agencies, but some have not been actively pursuing civil cases. This transmittal interprets Federal Regulations at 42 CFR 1007.11(a) to require that all provider fraud cases which the MFCU declines to pursue criminally, be investigated and/or analyzed fully for their civil potential. This guidance to the MFCUs should enhance the number of referrals that are

accepted by the MFCUs and should serve to further promote the integrity of the Medicaid program.

If you have questions concerning this report, you may contact Mark Rogers in the Atlanta Regional Office at (404) 562-7321 or E-mail mrogers@hcfa.gov.

Sincerely,

/s/

Rose Crum-Johnson
Southern Consortium Administrator

Enclosures
cc: State Medicaid Director
MFCU Directors
For: Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia, & Wyoming

REVIEWS OF STATE MEDICAID
PROGRAM INTEGRITY PROCEDURES

NATIONAL REPORT

FISCAL YEAR 2000

National Medicaid Fraud and Abuse Initiative

Health Care Financing Administration

Department of Health & Human Services

June 2001

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Executive Summary

In fiscal year 2000, HCFA's National Medicaid Fraud and Abuse Initiative (Initiative) performed program integrity reviews in eight States: Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia, and Wyoming. The reviews had two main purposes: Determine whether each State's program integrity policies and procedures comply with Federal statutory and regulatory requirements, and determine how States identify, receive and process potential provider fraud and abuse information. Additionally, we wanted to identify potentially beneficial practices occurring in States and learn how HCFA can assist States in improving their program integrity oversight by alleviating certain existing barriers that they identified.

Each State that was reviewed received a report that included any findings of regulatory non-compliance, proposed enhancements to current programs, potentially beneficial practices being utilized and barriers identified by the State. Proposed enhancements are suggestions presented by the review team to assure the State is in Federal compliance or to improve their program integrity efforts.

This National Report (Report) summarizes the potentially beneficial practices that States are using, and any proposed enhancements identified by the review teams which States feel have positive value. Also included are findings of regulatory non-compliance and barriers identified by the States that hinder their program integrity efforts. We collected almost a dozen barriers, some of which exceed our scope of authority. Toward that end, we will review, and where possible, take action or refer these issues to the appropriate group for its consideration. HCFA hopes that by sharing this information in a National Report, States can implement some of the identified potentially beneficial practices and proposed enhancements from other States, depending on their needs.

This Report is organized into five functional areas: *Excluded Providers, Provider Enrollment, Surveillance and Utilization Review Subsystem* (SURS), *Managed Care*, and *Medicaid Fraud Control Unit* (MFCU). Within each functional area, we discuss the relationship of potentially beneficial practices and proposed enhancements to the three themes the reviewers identified that were found to exist in almost all of the States. The three themes are "**Resources**," "**Communication**," and "**Technology**."

In analyzing the reviews, we found that the eight States varied greatly in their Medicaid program integrity practices, often due to the vast differences in size among the States. (See Attachment – Medicaid Population Comparative Chart) In our analysis of the individual reports, we found no overwhelming patterns or trends of potentially beneficial practices or areas of weakness in fraud and abuse operations, mainly because of the flexibility the States have in creating their programs.

Generally, States were meeting their program integrity responsibilities satisfactorily. In the eight reviews, only two findings of regulatory non-compliance were identified. Also identified during the reviews were three situations that were not within the original scope of our reviews, where a State was not in compliance with Medicaid regulatory or policy requirements. Although these

latter areas of non-compliance were not considered "findings" in the individual review reports, the States were made aware of the non-compliance.

The first of the three themes identified was resources. We found there were numerous resources and administrative authorities available to all the States' program integrity operations. Although the States were exercising most of their authorities and tapping many of their available resources, there were still occasions where full use of these resources was not occurring. For example, some States were not taking advantage of their authority to collect provider disclosure information relating to subcontractors and suppliers. Collection of this disclosure information can be a valuable resource, but if not requested by the State, it remains an untapped source. Another important information source not typically utilized is State managed care data. We found some States did not include their Medicaid managed care system in their program integrity plan or use managed care information in their fraud prevention efforts. The extent to which States made full use of available resources had an impact in all five functional areas.

The second theme identified was communication. We found the presence of good communications with internal and external partners, or lack thereof, to be a recurring factor in the relative success of a State's program integrity operation. Some States had strong communication with their Medicaid Fraud Control Unit (MFCU), leading to a remarkable working relationship that produced information sharing, learning, and added success. Other States though, lost opportunities through poor communication with internal and external partners. For example, several States' program integrity units did not communicate or exchange information with their own managed care programs or Managed Care Organizations (MCOs). Valuable encounter data, provider enrollment or sanction information, and fraud patterns were not being shared, and therefore were not utilized in fraud prevention. The States' level of communication affected all five functional areas.

The last crosscutting theme we identified as influencing multiple functional areas is technology. Technology also can be considered a "resource," but due to its significant impact on program integrity operations, we address it separately. Cutting-edge technology can be very valuable to a State's program integrity activities. It can add greater efficiency and produce superior results. For example, one State had a specialized software package that enabled it to identify a greater number of questionable claims. Identifying more questionable claims translates to greater recoveries. Without up-to-date technology, efficiency can be hindered and information may be inaccessible. Although some States are using advanced technology, other States' efforts are hampered by outdated systems.

In order to distinguish between potentially beneficial practices and proposed enhancements, we have labeled potentially beneficial practices with a "🏆" and proposed enhancements with a "🛠." Additionally, we identified particular areas where the Initiative or HCFA, in general, may be a potential resource, and noted these informational items with an "η."

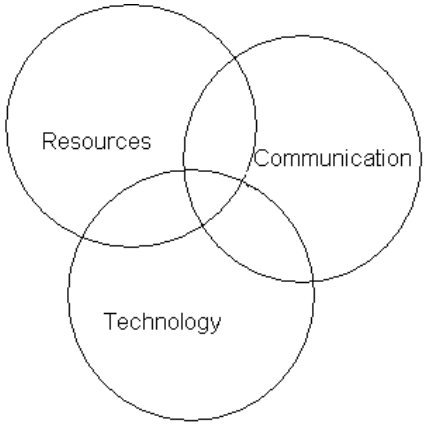
Oversight and Partnering

In January 2000, the National Medicaid Fraud and Abuse Initiative began conducting reviews of State program integrity operations to determine how States identify, use, coordinate and communicate fraud and abuse information. National teams consisted of staff from the Initiative who performed reviews in the following eight States: Georgia, Illinois, Nebraska, Nevada, Oklahoma, Vermont, Virginia and Wyoming. By conducting these reviews, HCFA is addressing its responsibility to provide oversight of State program integrity functions while at the same time fulfilling a commitment to support State partners who are fighting Medicaid fraud and abuse.

From an oversight perspective, we want to determine if States are in compliance with Federal laws and regulations by reviewing policies and procedures. As a partner, we want to identify ways in which States can improve the integrity of their Medicaid programs. In addition, as a partner, it is important to identify barriers States feel limit their ability to ensure the integrity of their programs.

Themes

Three themes emerged from our analysis of the potentially beneficial practices and proposed enhancements identified in the reviews. **Resources**, **Communication** and **Technology** surfaced as themes in almost every functional area reviewed. While we understand that these themes can all be considered resources, we found them significant enough to stand on their own.



For purposes of this report, themes are defined as follows:

- **Resources** are internal and external information and program oversight authorities that are available to the States.
- **Communication** is the sharing and exchanging of information between internal and external partners, including outreach activities.

- **Technology** is informational systems to access or manipulate information, including software and hardware tools for data processing and analysis.

We will relate each functional area addressed in the reviews (Excluded Providers, Provider Enrollment, SURS, Managed Care, MFCU) to these themes during the following discussions as the themes apply.

Outcomes

This National Report is a compendium of information obtained from the individual reviews conducted during FY 2000. The individual review reports include findings of regulatory non-compliance, potentially beneficial practices, and proposed enhancements. Two findings of regulatory non-compliance were identified during the reviews. Also identified were three situations not within the original scope of our reviews, where a State was not in compliance with Medicaid regulatory or policy requirements.

The two findings of non-compliance dealt with two different regulatory requirements. The first one, at 42 CFR 455.106(a)(2), requires the collection of conviction and ownership information. The HCFA review teams identified one State that failed to require disclosure of conviction or ownership information in the provider application, provider agreement or in any other format. The second regulatory requirement, at 42 CFR 455.20, requires States to verify with beneficiaries whether services billed by providers were actually received. One State reviewed had no method in place to verify with beneficiaries that services billed by providers were actually received and were appropriate. Both of these regulatory requirements are important elements of oversight operations. By instituting appropriate corrective actions, States should reduce the risk of fraud and abuse in their Medicaid programs.

Also found were three areas where States did not meet the requirements contained in other sections of the Federal regulations or current HCFA policy. Although these three areas were not within the original scope of the program integrity reviews and were not considered "findings" in the individual review reports, States were made aware of the non-compliance so that corrective action could be taken. One State was found not to have a post payment review process, as required by 42 CFR 447.45(f)(2) and 42 CFR 456.23. Another State was only executing provider contracts with frequently used out-of-state providers rather than all out-of-state providers, as required by 42 CFR 431.107(b). That State also was not following the longstanding HCFA policy which does not permit providers to bill beneficiaries for missed appointments. Although outside the original scope of the program integrity reviews, non-compliance with these regulations poses a weakness to States' program integrity efforts.

During the Federal on-site visits, many instances of potentially beneficial practices were identified. The reviews also identified a number of proposed enhancements. These potentially beneficial practices and enhancements propose an assortment of ideas and techniques States can adopt. This report will be shared with all States, and should be used as a tool to help them comply with Federal regulations and improve their operations.

In order to distinguish between potentially beneficial practices and proposed enhancements, we have labeled potentially beneficial practices with a "🏆" and proposed enhancements with a "🛠." Additionally, we have identified particular areas where HCFA may be a potential resource, and noted these informational items with an information symbol "η."

What Can Be Gained From This Report

HCFA is sharing these effective program integrity policies and procedures so that States can assess where they are along the fraud and abuse prevention continuum. We believe all States have the potential to benefit from policies and procedures currently existing in one or more of the eight States reviewed, as well as the enhancements cited by the various review teams. For example, if a State has a minimal fraud and abuse effort underway, they can easily implement improvements from any or all of the functional areas mentioned below and derive immediate benefit. Even States with an aggressive history of fighting fraud and abuse can strengthen their existing policies or break new ground by incorporating some of the more innovative procedures suggested in this report or that already exist in other States. In addition, we believe that even highly proactive States can benefit by identifying procedures not yet undertaken in their State. States should be aware, however, that adoption of some of these procedures may require a change in State law.

η The Medicaid Fraud Statutes Web Site at http://fightfraud.hcfa.gov/mfs identifies States with statutes involving various fraud and abuse topics, and the actual legislative language.

An effective program integrity operation ideally begins with the ability to prevent abusive providers from entering a State's Medicaid program in the first place. However, efforts to exclude problem providers can falter and even existing compliant providers may become abusive. An effective program integrity operation can more quickly identify abusive providers and practices to minimize their impact on beneficiaries and cost to the program. That is why collecting and having access to detailed provider information is so important. Additionally, sharing details about aberrant providers and practices with other States will help program integrity efforts in all States. The following discussion should help the reader prepare or enhance their program integrity plan of action.

Excluded Providers

States have many different ways of excluding problem providers from their Medicaid programs. Section 1902(a)(39) of the Social Security Act outlines the exclusion requirements. The review teams found that State procedures and practices to identify excluded providers vary widely. These procedures ranged from relying mistakenly on another State agency to search for excluded providers to routinely searching the complete List of Excluded Individuals and Entities (LEIE). The following are policies and procedures that were effective in the States we reviewed.

Resources Theme:

- Use the complete LEIE (historical and HCFA Publication 69 updates) for all provider applications and re-enrollments. Some States are using only Publication 69 and not the entire LEIE. Publication 69 contains only updates to the complete LEIE history file, thus increasing the State's risk of doing business with excluded providers.

Communication Theme:

- Share provider exclusion information between Medicaid and other State employee health benefit insurance programs. One State has made it known that any time a provider is denied enrollment, excluded or sanctioned from the State Medicaid program, notice of that action will also be given to the State employee health benefit program, which covers all State employees and teachers. Depending on the number of State employees, the loss of such an important patient base can be an added deterrent to providers contemplating fraud.

Technology Theme:

- One State posts a list of excluded providers on the Internet to allow the general public, Managed Care Organizations (MCOs) and other providers to readily see which specific parties have been excluded in their State. This can educate providers so they won't hire or inadvertently do business with these excluded parties. This State's Web site also contains links to the HHS/OIG and State licensure board's sanction Web sites.
- Automate the identification process linking excluded providers to enrollment applications and the existing provider base. One State created a system to take the monthly Publication 69 updates and automatically compare them to its active provider network. This comparison process is a useful and efficient tool in identifying and keeping out or removing from the Medicaid program, all recently excluded providers. We should note that, in order for a State to assure itself that no excluded providers are participating in the Medicaid program, the entire LEIE must be searched. This is because the monthly Publication 69 lists are not cumulative and do not contain all the providers in the entire LEIE. By relying solely on the monthly Publication 69, a State would miss any existing excluded providers that are already in the Medicaid system.

Provider Enrollment / Credentialing

The gateway for abusive providers to enter a State's Medicaid program is through the provider enrollment process. Therefore, provider enrollment is the point where providers can be denied access or asked to provide various credentials to help validate their existence and provide valuable background information to the State. For example, disclosure of convictions and ownership information provides important insight when making a determination whether to allow a provider into the program or allow them to remain in the program. An effective disclosure database can include information on subcontractors and related organizations that can also be of assistance in other Medicaid areas, like financial audit. The collection of much of this information is required by regulations at 42 CFR 455 Subpart B. In addition, non-required

disclosure information can be added to existing requirements in order to build a more complete provider history.

States practice a wide range of provider enrollment activities, from not collecting the required conviction information to annually re-enrolling providers and conducting on-site inspections. The following are potentially beneficial policies and procedures that were identified in the States reviewed. Also included are enhancements States agree have some merit:

Provider Enrollment Policies

Resources Theme:

- 🏆 Routinely re-enroll all Medicaid providers to update disclosure information, monitor those providers subject to annual license renewal, and assure that provider numbers are only assigned to active providers. One State actually re-enrolls providers annually through a user-friendly Web site that also allows them to simply update applications to include physician assistants.
- 🏆 Place providers into a non-participating status after 12 months of billing inactivity, and remove from the program after 12 additional months if the inactivity continues. This will help prevent active provider numbers from being inappropriately used to bill for services not rendered.
- 🏆 For institutional providers that are certified for Medicare and Medicaid, one State uses the provider's Medicare number as the Medicaid provider number. This can be beneficial in claims processing for dual eligibles.
- 🏆 Perform targeted onsite visits to potentially problematic or new providers in selected provider groups. One State targets a particular provider type for on-site visits while another State visits all new providers. These visits will verify the existence of the provider and validate that the provider meets certification standards in its designated category of service.
- 🛠 Add to the provider application an attestation or certification that the information is true and complete, with penalties of perjury under State and Federal law. This can aid in the prosecution of a provider by giving the State an additional cause of action option to pursue.
- 🛠 Use the authority granted to States by provisions of the Balanced Budget Act of 1997. For instance, a State could determine that allowing a physician with a record of felony convictions for drug abuse, to be a provider would be inconsistent with the best interests of its beneficiaries.

Communication Theme:

- 🏆 Notify the provider community, including Managed Care Organizations, regarding sanctioned individuals so Medicaid providers will be less likely to hire or do business with them. One State mails a sanction list to the provider community, that includes some OIG exclusion information.
- 🏆 Exchange information on questionable providers with adjacent States. One State shared information with a bordering State about providers in a targeted group. This helps surrounding States identify potential fraud and abuse as well as prevent questionable providers from migrating and enrolling in each State's program.
- 🛠 Make all disclosure information available to other Medicaid staff. Information like related organizations and subcontractors can be beneficial to program integrity case development and to financial audits.

- Open a communication line with State survey staff. The surveyors go on-site and collect operational and organizational provider specific information that may be useful. Any information that can help show related organizations, subcontractors, ownership and quality of care information can be very informative to a State's program integrity, provider enrollment and financial units.

η HCFA is in the process of allowing Medicaid cases to be entered into the Fraud Investigation Database (FID). This database currently provides valuable information about potentially fraudulent Medicare providers that can aid State provider enrollment units when deciding to enroll or re-enroll a provider. With the addition of Medicaid cases, all State program integrity units, Medicaid Fraud Control Units and Medicare contractors will be able to see if a potential provider has an abusive history.

Credentialing

Resources Theme:

- Upon initial enrollment, verify the validity of provider licenses presented as proof of professional standing. One State contacts the licensing board to determine when the applicant was licensed. This decreases the likelihood of any misrepresentation of licensure status by the applicant.
- Routinely request and update historical conviction (from Federal or State medical assistance programs) information from providers as stipulated in 42 CFR 455.106. This information is required before the Medicaid agency enters into or renews a provider agreement, but can be requested at any time. Owners, managing employees or other persons who have a controlling interest in the provider can be a target of the request. At the same time a State is requesting conviction information, it may be beneficial to also collect similar sanction information.
- Consider criminal background checks (on a targeted basis) for as many provider types as deemed appropriate by the State. These background checks can reveal convictions that were not voluntarily disclosed by the provider.
- Request and collect disclosure information from providers concerning sub-contractors and suppliers as provided in 42 CFR 455.105. This information can reveal related organizations and the possible existence of kickbacks and other improper relationships.
- Review the contractual relationship between a provider and its designated billing payee to verify it is in compliance with 42 CFR 447.10. State payments for Medicaid services to anyone other than a provider or recipient are prohibited, except in special circumstances. For example, payments may be made to a business agent such as a billing service if the agent's compensation is related to the cost of processing the billing; not related to the amount billed or collected; and not dependent upon the collection of the payment.
- Routinely check with out-of-state licensure boards to validate licenses presented as evidence of professional status.

η Medicare has recently modified its enrollment and credentialing standards. These standards can be accessed at www.hcfa.gov/medicare/enrollment and incorporated into any State's procedures.

Surveillance and Utilization Review Subsystem

A State's Surveillance and Utilization Review Subsystem (SURS) unit has the responsibility to investigate Medicaid paid claims for the possibility of fraud or abuse. In some State SURS operations, every Medicaid paid claim has at least some slight chance of being selected for review. It is this deterrent that helps to create a "sentinel effect" against abusive providers.

Regulations at 42 CFR 447.45(f)(2) require that the States conduct post-payment claims reviews that meet the requirements of parts 455 and 456 which deal with fraud and utilization control. HCFA does not set specific requirements in terms of a minimum number of reviews of each provider type. Instead, States can be innovative and devote their energies and resources in a manner that they believe will prove most beneficial.

Regulations at 42 CFR 455.1(a)(2) require that a Medicaid agency be able to verify that services billed by providers were actually received. Most States send out Explanation of Benefits (EOB) statements to a sample of Medicaid recipients, requesting feedback if the clients believe that the medical services were not rendered. One State does not use this or any method to validate the receipt of services. Whether or not this EOB methodology is used, the requirement to verify that services are received must be met. In contrast, another State that utilizes EOBs, has an otherwise virtually ineffective post-payment review process.

One of the main purposes of our Program Integrity reviews was to determine how SURS operations identify and use fraud and abuse information. Below is a summary of the workings which we observed, both the potentially beneficial practices and areas of proposed enhancement. States indicated a willingness to consider innovations that are mentioned here.

Resources Theme:

- One State suffers from a scarcity of medical professionals in certain geographic areas. When abusive providers are identified, the State tries to balance its need to assure that beneficiaries have adequate medical coverage, with the need to sanction improper behavior. The State's solution is to allow these providers to continue to participate in the Medicaid program by utilizing compliance agreements and closely monitoring performance.
- Fraud and abuse cases involving quality of care issues are difficult to document and prove. On-site investigations and involvement of medical professionals are necessary review elements. One State is hiring a behavioral health clinician to both work in the field and also provide expert testimony in court.
- One important source of information for fraud and abuse analysis is a State's previous case reviews. One State is updating its MMIS, which will allow SURS to conduct a computerized comparison among already-completed cases. The State expects to detect patterns of abuse by other providers, based on documented instances of misconduct by similar providers.
- One state found the services of a statistician to be important to its SURS. The statistician monitors samples for statistical accuracy, and projects total misspent funds extrapolated from individual reviews.

- In order to maximize the likelihood of a positive resolution of a case review, one State conducts formal "pre-reviews" of potential fraud cases, to identify candidates unlikely to be successfully prosecuted and possibly target them for administrative remedies.
- It is important for SURS to evaluate all provider types and services within its Medicaid program. The potential that any claim could be selected for a program integrity review provides a "sentinel effect" to discourage providers from abusive practices. Managed care services should be monitored for potential fraud and abuse just as closely as those provided under fee-for-service, because of the incentives to commit fraud and that approximately one-half of all Medicaid beneficiaries are now receiving services in a managed care environment.
- SURS should include denied claims in the program integrity review process. This is important because unscrupulous providers submit claims to test the waters in order to find denial parameters.
- Provider profiling reports should be generated at least quarterly, to promptly address situations involving questionable billing patterns, and to minimize the dollar impact of any abusive provider practices.
- Case activity should be thoroughly documented. Documentation is necessary for a proper audit trail and any decision to recoup, to sanction, or to refer to the MFCU. It is also useful to provide feedback for others who may review the record later, as a learning tool.
- There should be a centralized point for all referrals from the Medicaid State Agency to the MFCU, to track cases and to better understand the patterns of activity involved.

Communication Theme:

- SURS units should cultivate an active relationship with the MFCU to enhance cooperative efforts. Some States we reviewed have regular meetings with SURS and MFCU, resulting in more successful case operations.
- In some States, the MFCUs are utilized as a resource to train SURS staff to better identify and document cases for referral.
- States that share provider and case information with other nearby States can increase the detection of fraudulent providers and abusive interstate practices. This communication aided one State in its investigation of a pharmacy case involving pharmaceutical sales representatives who were also present in a neighboring State.
- States can use pro-active outreach activities including the education of providers and beneficiaries. As a proactive measure to avoid billing mistakes before they occur, one State's SURS has been training the State's Medicaid providers concerning allowable and acceptable utilization of services. SURS also trained providers on proper methodology of claims submissions, and the types of documentation that should be maintained on file.

Technology Theme:

- SURS units can install specialized software to enhance the ability to detect questionable claims. One State used a software package that will track and chart healthcare outcomes and trends.
- Some States created data warehouses to significantly increase available information. This step enhanced the sophistication of their data manipulation. One State found that five years' of invoices provided the computer with sufficient material to be able to recognize patterns too subtle to detect with only one year's history.

- One State has developed a computer program to detect a quick increase in any specific provider's level of billing activity. The monthly report that is generated permits SURS to investigate further before a large sum of Medicaid funds is involved.
- Several States have updated and expanded SURS technology in an effort to maximize the ability to detect and reduce fraudulent provider practices. Some States have increased the speed and flexibility of their data analysis capabilities with ad hoc reporting software on desk-top computers.

In addition to all of the above suggestions, there are other resources, developed by the Initiative, that are or soon will be available to the States.

η The first item, recently released, is a document titled: *Guidance and Best Practices Relating to the States' Surveillance and Utilization Review Functions*. Designed as a practical manual containing suggestions for improving a SURS operation, it contains examples of recommended practices and new ideas for conducting reviews. It can be read and downloaded in its entirety at the National Medicaid Fraud and Abuse Initiative Web site, located at: www.hcfa.gov/medicaid/fraud under "Reports."

η The second report is currently being developed and should be available in Fiscal Year 2001. It is an Information Systems document, which will be a comprehensive listing of all available automated systems that are being used to control Medicaid fraud, waste and abuse. We plan to post this document on our Web Site at: www.hcfa.gov/medicaid/fraud , so that States planning to enhance their existing MMIS will be able to intelligently analyze and compare available alternatives.

η As mentioned earlier in the Provider Enrollment section, HCFA is in the process of allowing Medicaid cases to be entered into the FID. This database currently provides valuable information about potentially fraudulent Medicare providers that can aid State provider enrollment units when deciding to enroll or re-enroll a provider. With the addition of Medicaid cases, all State program integrity units, Medicaid Fraud Control Units and Medicare contractors will be able to see if a potential provider has an abusive history.

Managed Care

More and more States are shifting to managed care instead of administering their Medicaid programs solely in the traditional fee-for-service fashion. Nationwide, over 50 percent of beneficiaries are enrolled in some form of managed care. These managed care systems present a new set of challenges to authorities attempting to prevent fraud and abuse.

There has been a common misconception that switching to managed care automatically eliminates fraud and abuse since each medical service is not individually reimbursed. Despite the change to a capitated payment system that shifts the risks from the State to the Managed Care Organization (MCO), fraud and abuse does exist in managed care. Fraud and abuse is still found in the traditional over-utilization type cases where MCOs reimburse their providers on a fee-for-

service basis. In this situation, a provider's incentive to over-bill remains. Potentially, this may also cause an increase in the capitation rate that the State pays the MCO. There is also under-utilization fraud, created by the managed care environment itself, where the MCO has an incentive to minimize the care they provide in order to maximize their profits. Ultimately, this can impact quality of care.

Although fraud prevention and detection is often viewed simply as an activity delegated to the MCO, the State agency has an important oversight role, as well as a gatekeeper role with its enrollment safeguards. Contract wording is of paramount importance in defining fraud and abuse detection roles and responsibilities. The States' Medicaid managed care programs are also a valuable but virtually untapped source of data for identifying fraudulent and abusive providers or trends in provided services. The following are examples of potentially beneficial practices and/or enhancements for fraud and abuse prevention and oversight in the managed care arena:

Resources Theme:

- Establish procedures to evaluate content and implementation of the program integrity plan submitted by the MCOs. After procedures are evaluated, program integrity policy and clear guidelines for MCOs should be established. These guidelines should include clear contract language delineating responsibilities for detection and referral of potential fraud for prosecution. Some States reviewed had no guidelines or policies in place. The ability to substantially reduce fraud and abuse in managed care can be greatly enhanced if methods and strategies are developed to coordinate efforts among the State and its MCO's. Without clarifying these roles and responsibilities, duplication of efforts may occur or key responsibilities may be neglected.

Communication Theme:

- States should meet regularly with MCOs to identify problem areas and share information. One State's managed care department had regular meetings with its MCOs that provided for an interactive forum. This allowed for discussion of potential areas of abuse and the status of activity relating to complaints against MCO providers and the MCO itself. These meetings aided in improved oversight of the MCOs as well as in general anti-fraud and abuse strategizing and brainstorming.
- One State designated a fraud and abuse point person or contact in each MCO with whom the State deals. It is important that the designated MCO fraud contact be an experienced, mid to high level employee, because this will result in more responsibility and accountability of the MCO relating to fraud and abuse issues.
- Include a State managed care representative at all task force and MFCU meetings. Involving a managed care representative at these meetings would further broaden the traditional fee for service perspective and the group's effectiveness.

η In an effort to assist our State partners, HCFA has recently released a document addressing issues concerning Medicaid managed care fraud and abuse, including what it is, where to find it, and how to prevent it. This document, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* can be read and downloaded in its entirety at the Initiative's Web Site, located at: www.hcfa.gov/medicaid/fraud under "Reports."

Medicaid Fraud Control Unit

One of the purposes in reviewing a State's Medicaid program integrity operation was to observe its relationship with the Medicaid Fraud Control Unit (MFCU). It is important to learn how the MFCU interacts with the Medicaid agency, and whether improvements can be made in coordinating the efforts of both groups. Although an evaluation of the MFCU itself was not performed (the DHHS/OIG reviews the MFCUs on a regular basis for certification and recertification), we did attempt to learn as much as possible about their operations.

The purpose of a MFCU is to investigate and prosecute cases of suspected Medicaid provider fraud. A MFCU can act in response to a referral from a program integrity unit, or on the basis of some other information or investigation, either internal or external. MFCUs typically have trained investigators, subpoena power, and attorneys who can handle a case in civil or criminal court.

In an ideal working relationship, a State's SURS unit and MFCU function as a team. They keep each other informed during the development of a fraud case. States in which SURS and MFCU staffs meet regularly seem to perform more effectively than States where contact is infrequent.

The reviewers found the degree of contact varied, from one State having staff located in the MFCU's office, to another State having sporadic or virtually no contact with the MFCU at all. Some degree of communication with the MFCU is necessary for case referrals, as required by regulations at 42 CFR 455.15, and evidenced by Memoranda of Understanding (MOUs). Good communication with the MFCU can be of immeasurable value to a strong program integrity effort. For example, one State had not only Medicaid program integrity staff in the MFCU office, but also an FBI staff member as well. In some States, the MFCU also integrates with the Federal agencies by designating certain attorneys as both Federal and State Prosecutors.

The following are practices that were effective in the States we reviewed:

Resources Theme:

- Include MFCUs in managed care contracts to permit them access to MCO information needed for case development and prosecution. One State actually had its MFCU as a party to the contract, which provided for full access to all records.
- MFCU involvement in developing fraud and abuse policy, and in drafting or reviewing contract language for provider agreements and managed care contracts can be very beneficial. The MFCU was used by one State as a technical resource and consultant which aided the State's policy and oversight functions at meetings and in contract language development.

Communication Theme:

- MFCU can train SURS staff on how to develop and refer potential fraud cases. One State's MFCU distributed written guidelines and provided training for SURS on what to look for in a fraudulent case. Training the SURS on case development and the prosecutorial needs of the MFCU will prevent duplication of work and allow for better efficiency, awareness, and ultimately better case referrals.

- Develop a case referral form for the SURS. Some States reviewed used incident report/referral forms, that the MFCUs took part in developing. This ensured that all necessary information was provided for each referral. Some MFCUs also would send to the SURS unit written acceptances/declinations, which provided feedback and assistance in referral tracking.

Other

The Initiative reviewed targeted areas that are traditionally included in program integrity functions. During the reviews, some effective, unique and innovative processes and functions that some States had in place were discovered. Included in this report are non-traditional program integrity processes and initiatives, that represent creative and innovative thinking. These items can help States use or identify resources that might have been overlooked or simply not considered for program integrity efforts. Two examples are one State's relationship with its State Department of Audits and another's creation of a "think tank."

- One State agency dealt with its lack of resources for a large auditing effort by executing a contract with its State Department of Audits (Audits). Audits now assists in data mining and provider audits. This was a new undertaking so its effectiveness has not yet been quantified.

- Another State had created an anti-fraud "think tank" to conduct innovative fraud and abuse research. This group of people consisted of former quality control reviewers, investigators, and SURS analysts, many with multiple years of experience. The "think tank" looks for fraudulent service patterns that go beyond the scope of SURS, through the application of superior technology.

  The "think tank" utilizes a data warehouse containing three (and soon to be five) years of claims information, and data mining software to look for unusual patterns that might indicate provider abuse. Additional new software detects claims with incongruous billing code combinations. The State can also link related service claims, such as emergency transportation invoices and hospitalization claims for the same client.

One particularly effective action is the "spiked payment" report designed to quickly recognize potentially abusive changes in a provider's billing pattern. The State can identify a provider who is increasing his/her level of activity much sooner than would be possible without the specialized software.

This report can also detect patterns of aberrant behavior in pharmacy practices, such as early prescription renewal, excessive numbers of 1-day drug supplies, or multiple prescriptions for the same recipient, on the same day, for drugs from the same therapeutic class.

It is clear that the application of "high-tech" computer resources will go a long way toward deterring abusive providers. It should also be noted that one of the features instituted by this forward-thinking "think tank" is the creation of a software program to randomly select some

claims for review from every service type, so that every paid claim has at least some chance of being selected.

State Identified Barriers

Some States believe certain situations hinder their ability to effectively fight fraud and abuse. In HCFA's leadership role, it is important to identify the issues brought to our attention during the reviews. Additionally, these issues will be reviewed and, where possible, action taken. When necessary, any unresolved issues outside our scope of influence will be referred to an appropriate group for consideration. The issues noted are:

- Exclusion Information - The HHS/OIG exclusion information sent to the State should contain more valuable information like tax identification numbers, Social Security Numbers, and other information that help to identify the provider. The information should be provided in a data file format.

- Data Exchange - HCFA should provide direction and do more to facilitate the exchange of recipient and provider information with Medicare and other parties.

- Sanction Authority - States need Federal sanctioning authority to revoke the eligibility of recipients who have not been convicted of fraud, but continually abuse the program.

- SPR Guidelines - Guidelines are needed to take the place of the System Performance Review (SPR) requirements that were eliminated by the Balanced Budget Act. This would help to demonstrate why certain staffing levels are needed within the SURS.

  η In an effort to assist our State partners, HCFA has recently released a document addressing issues concerning Medicaid managed care fraud and abuse, including what it is, where to find it, and how to prevent it. This document, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* can be read and downloaded in its entirety at the Initiative's Web Site, located at: www.hcfa.gov/medicaid/fraud under "Reports."

- Tracking Mechanism - There should be more effective mechanisms in place to be able to track payees who have been identified as involved in fraud or billing abuses in the program.

- 60-Day Rule - HCFA should re-assess the provision under 42 CFR 433.312 that allows State Medicaid Agencies just 60 days from the date of discovery of an overpayment to refund the Federal share to HCFA. The 60-day rule is considered a disincentive that is unfair and punitive because States usually do not recover the overpayment before the Federal share is to be returned.

- HIPAA Coding Standards – Having begun to work through the required Health Insurance Portability and Accountability Act (HIPAA) changes, SURS staff noted that, in contrast to the State's very specific codes, the HIPAA codes are too general for the State's needs. In

addition, there were no fraud and abuse codes in the national coding structure at the time of the review. Similarly, there is no national equivalent to the program integrity/utilization review "catchall" State code used by the State.

- PRO Relations – SURS investigators indicated that a lack of information sharing on the part of the Federally-designated Professional Review Organizations (PRO) had sometimes been a hindrance to State action in case development. The State had issued a Request for Proposals at the time of the review, and was in the process of looking at other options for medical necessity review support. The State remained in the position, however, of having to work with the PRO in the meantime. In this situation, the HCFA Regional Office was notified of the situation, to pursue any support or resolution that it might offer to alleviate this hindrance to the State's program integrity efforts.

- Federal Match – The Federal Financial Participation (FFP) match for all SURS activity be increased from 50 percent to the 75 percent for which a MFCU would qualify. This request has particular significance in one State, where the SURS unit has stepped in under the MFCU waiver and taken on many of the functions normally handled by a MFCU.

- Managed Care - A State mentioned its desire to receive assistance from HCFA in fraud prevention in the managed care arena.

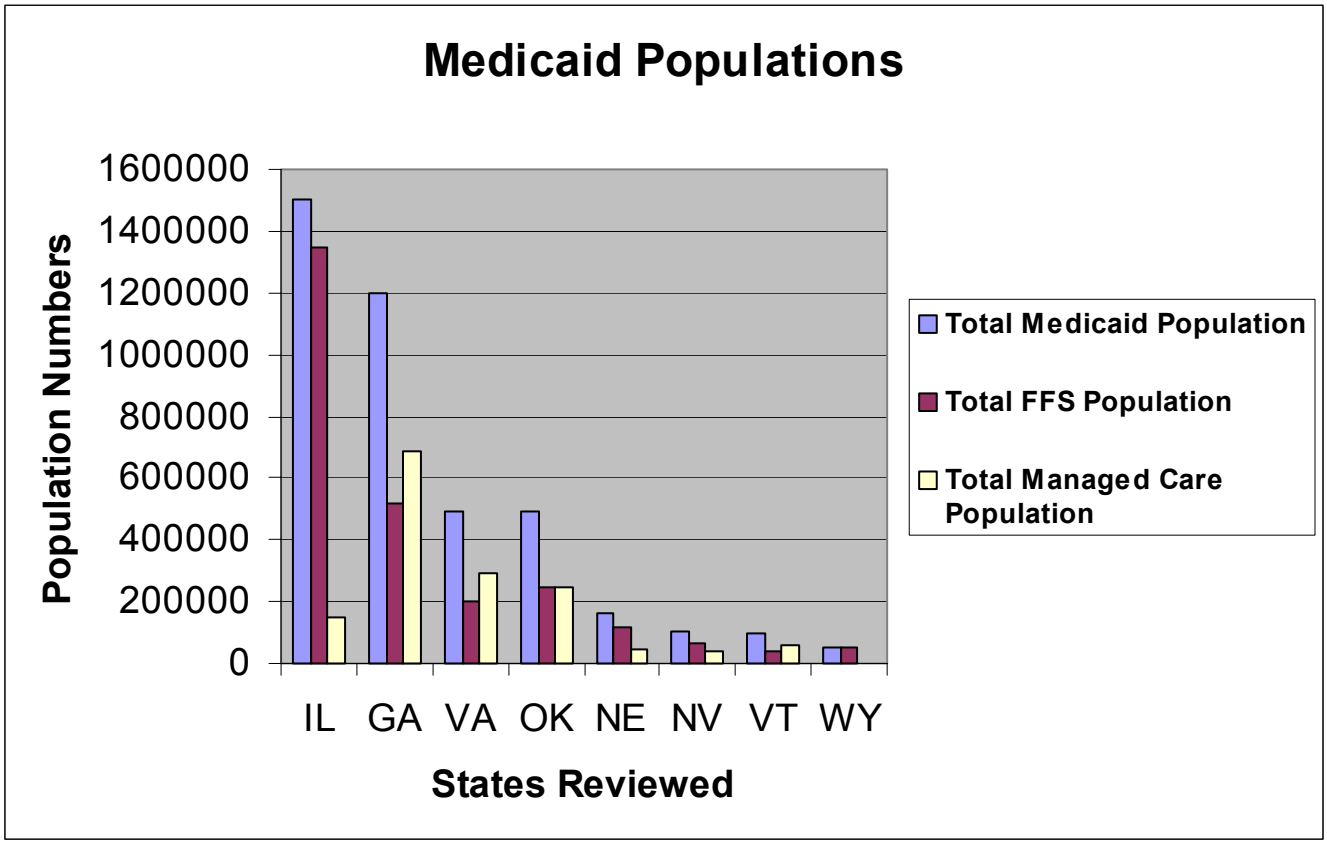
- State OIG Referrals - A State expressed its frustration over having regularly referred State Medicaid provider terminations to the Department of Health and Human Services/Office of Inspector General (DHHS/OIG) and that rarely, if ever, has DHHS/OIG implemented a federal exclusion based on the State termination action.

What's Next

HCFA believes these reviews highlight its commitment to provide States with assistance in their fight against fraud and abuse, while at the same time fulfilling its oversight responsibilities. The reviews indicated that States are generally meeting their program integrity responsibilities. By incorporating the proposed enhancements, and potentially beneficial practices, where applicable, States have a real opportunity to improve their program integrity functions. States can access this report and others by logging onto our Web site at www.hcfa.gov/medcaid/fraud. If additional clarification of any idea expressed in this report is needed, please contact your HCFA Regional Medicaid Fraud and Abuse Coordinator for assistance.

ATTACHMENT:

Medicaid Population Comparative Chart



TO : All Medicaid Fraud Control Units

SUBJECT: State Fraud Policy Transmittal No. 99-01
Investigation, Prosecution, and Referral of Civil Fraud Cases

The purpose of this transmittal is to clarify the Office of Inspector General (OIG) policy with respect to the investigation, prosecution, and referral of civil cases by State Medicaid Fraud Control Units (MFCUs).

The authorizing statute for the MFCUs provides in section 1903(q)(3) of the Social Security Act that a MFCU "function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under [Title XIX of the Social Security Act]." See also 42 C.F.R. 1007.11(a).

The first priority for MFCUs has been, and remains, the investigation and prosecution, or referral for prosecution, of criminal violations related to the operation of a State Medicaid program. However, in recent years, both State and Federal prosecutors have increasingly relied on civil remedies to achieve a full resolution of health fraud cases. The assessment of civil penalties and damages is an appropriate law enforcement tool when providers lack the specific intent required for criminal conviction but satisfy the applicable civil standard of liability.

We understand that the approach to potential civil cases varies greatly among the MFCUs. We are concerned that for those MFCUs that do not perform civil investigations, meritorious civil remedies may go unpursued when no potential criminal remedy exists. Civil cases could be prosecuted under applicable State civil fraud statutes or could be referred to the Federal Government for imposition of multiple damages and penalties under

he Federal civil False Claims Act. Alternatively, if authorized by the Department of Justice, the OIG may seek assessments and penalties under the Civil Monetary Penalties Law. Also, in addition to or as an alternative to monetary recoveries, the OIG may seek to impose a permissive exclusion from Medicaid and other Federal health care programs.

Accordingly, OIG interprets section 1903(q)(3) of the Social Security Act and section 1007.11(a) of Title 42, Code of Federal Regulations, "Duties and Responsibilities of the Unit," to require that all provider fraud cases that are declined criminally be investigated and/or analyzed fully for their civil potential. OIG further interprets 42 C.F.R. 1007.11(e), requiring a MFCU to "make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance" under the program, to say that if no State civil fraud statute exists, or if State laws do not allow the recovery of damages for both the State and Federal share of the Medicaid payments, meritorious civil cases should then be referred to the U.S. Department of Justice or the U.S.

Attorney's Office, as well as the appropriate Field or Suboffice of the Office of Investigations, OIG.

In sum, meritorious civil cases that are declined criminally should be tried under State law or referred to the U.S. Department of Justice, the U.S. Attorney's Office, or the Field or Suboffice of the Office of Investigations, OIG.

If you have any questions regarding this transmittal, please contact Joseph Prekker, Director, State Medicaid Oversight and Policy Staff. He can be reached at (202) 619-3557.

Frank J. Nahlik
Assistant Inspector General
for Investigative Oversight
and Support